Claims Clues

A Publication of the AHCCCS Claims Department February, 2000

Automated Medicare Crossover Begins

The AHCCCS Administration has successfully completed its first automated Medicare crossover production cycle with BlueCross/BlueShield of Texas (Trailblazers).

When a provider submits a Medicare claim to BlueCross/BlueShield of Texas for an AHCCCS recipient, the claim will be automatically crossed over to AHCCCS when Medicare issues payment. These providers no longer will need to submit claims to AHCCCS for claims paid by Medicare on or after Dec. 1, 1999. This automated crossover process includes claims for QMB Only recipients.

All Medicare crossover claims will be identified on the provider's remittance advice.

Denied and adjusted Medicare claims will not be automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS and must comply with the AHCCCS claim submission requirements.

AHCCCS also is initiating an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/BlueShield of North Dakota and BlueCross/BlueShield of Arizona. This process should be in place soon, and AHCCCS will notify providers of the change. ❒

Guidelines Offered for QMB Only Claims

Providers who submit QMB Only claims to the AHCCCS Administration can help expedite processing of these claims by ensuring that claim forms are completed properly.

AHCCCS began processing fee-for-service QMB Only claims on October 1. Prior to October 1, providers were required to send QMB only claims to the TPA.

The AHCCCS Claims Department has been special handling these claims in order to smooth the transition for providers. However, this process will soon end, and these claims will be processed in accordance with the standard procedures for all fee-for-service claims

When submitting QMB Only claims to AHCCCS, providers must follow these claim submission rules:

Coinsurance and Deductible

The Medicare coinsurance and deductible, if applicable, must be entered in Field 24K of the HCFA 1500 claim form. Enter coinsurance first and the deductible as the second figure.

Providers may not "zero fill" both of these fields. If Medicare denies a claim, AHCCCS will not make any reimbursement to the provider.

When submitting a HCFA 1500 claim for a Medicare HMO member, the charges in Field 24F must be the provider's billed charges, not the co-pay amount. The co-pay amount must be entered in Field 24K as coinsurance with a zero entered as the deductible.

Coinsurance and deductible must be entered in Field 41 of the UB-92 claim form using value code A1 to indicate Part A deductible and A2 for Part A coinsurance, if applicable.

Provider ID Number

Providers must enter their AHCCCS provider ID and 2-digit locator code in the "PIN#" section of Field 33 of the HCFA 1500. A facility's AHCCCS provider ID number must be entered in Field 51 of the UB-92.

Submission of Claims

Providers should send QMB only fee-for-service claims to:

AHCCCS Administration
Attn: Lori Petre
P.O. Box 25520
Phoenix, AZ 85002

Providers should write "QMB Only" on the envelope and include the Medicare EOMB with the claim.

Providers with questions about the *status* of QMB Only claims

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Guidelines Offered for QMB Only Claims

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should call the Claims Customer Service Unit at (602) 417-7670 (Option 4).

Providers with questions about *submission* of QMB Only claims should call (602) 417-7940.

The following policies apply solely to QMB Only claims:

- Timeliness requirements
  - QMB Only claims will be considered timely if initially received by AHCCCS within six months from the date of Medicare payment.
  - The claim must achieve clean claim status within 12 months from the date of Medicare payment.
- UB-92 discounts/penalties
  - AHCCCS will not take a quick pay discount nor pay a slow pay penalty on UB-92 QMB Only claims. ❒

Lab Claims for Dialysis Patients Face Review

Effective with claims for dates of service on and after February 1, AHCCCS will conduct a prepayment review of all fee-for-service claims for laboratory services performed for dialysis patients.

The following documentation justifying medical necessity must be submitted with each claim:

- Results of the laboratory tests
- Physician's orders for each test
- Medical documentation demonstrating that the test is medically necessary

Services for which all the required documentation is not provided will be denied. Providers who submit documentation after the claim has been submitted to AHCCCS must write the AHCCCS Claim Reference Number (CRN) on the documentation. The documentation will be imaged and linked to the claim.

Dialysis facilities are reimbursed a composite rate that includes certain laboratory services. The dialysis facility is responsible for the reimbursement of these laboratory services.

Services included in the composite rate may not be billed separately to AHCCCS unless they are ordered by a physician, medically necessary, and provided more frequently than specified by policy. Other separately billable laboratory services may be covered by AHCCCS if they are ordered by a physician and medically justified by documentation.

AHCCCS follows Medicare policy for billing and reimbursement of laboratory services for dialysis patients. ❒

Z3716 Limited to Non-emergency Air Transport

The AHCCCS-specific code Z3716 (Non-ambulance transportation; per mile) may only be used to bill for non-emergency air transportation services.

All other transportation providers are restricted from using that code.

Non-emergency air transportation providers must obtain prior authorization to bill for mileage using Z3716.

There are other AHCCCS-specific codes for billing non-emergency ground transport services. Transportation providers who have questions about codes that they may bill should contact the Claims Customer Service Unit at:

- Phoenix area: (602) 417-7670
- In state: 1-800-794-6862, Ext. 7670
- Out of state: 1-800-523-0231, Ext. 7670 ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 10 (Podiatrist)

- Add 29893 effective 01/01/1998
- Add 15000 - 15241 and 15350 - 15401 effective 01/01/1999

Provider type 23 (Home health)

- Add 94642 effective 10/01/1998
- Add Z3082 effective 10/01/1996

Provider type 24 (Personal care)

- Add Z3082 effective 10/01/1996

Provider type 37 (Homemaker)

- Add Z3082 effective 10/01/1996

Provider type 39 (Habilitation)

- Add Z3082 effective 10/01/1996